

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05189

05187

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Rt #1, Box 302</u>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>William</u> Last <u>Gosh.</u>		4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Gosh.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Presbury.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-54-7000T</u>	
17. INFORMANT <u>Mrs. Carrie Gosh, Harre-de-Grace Md.</u>		Address <u>Rt #1 Box 302</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.C.V.D.</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>? year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus + Malnutrition.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-19, 1967</u> to <u>4-26, 1967</u> , that (I) (we) last saw the deceased alive on <u>4-26, 1967</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>4/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harre-de-Grace, Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 30, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. James A.M.E. Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Harford Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Helia J. Bullock</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Harre-de-Grace Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 5 1967</u>			

02187

02187



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05190

CERTIFICATE OF DEATH

05188

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY in 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARford Memorial Hosp.</u>		e. STREET ADDRESS <u>ALLIBONE Rd. (RFD#1, Box#224)</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Fielder</u> Last <u>BLACK</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1890</u>
9. AGE (in years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Grayson Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID BLACK</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-14-7122 A</u>	
17. INFORMANT (Son) <u>838-3269</u> Address <u>224#1, Box#224, Bel Air, Maryland 21014</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive and Arteriosclerotic</u> DUE TO (c) <u>Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 27, 1967</u> to <u>April 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 29, 1967</u> , and that death occurred at <u>1:40</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo</u>		22b. DATE SIGNED <u>April 29, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Haure de Grace, Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>May 1, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air, Harford Co., Maryland 21014</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REGISTRAR <u>W. Broadway &amp; Williams St.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 2 1967</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05191

05189

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>N.Y.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hayward Grade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Rochelle</u> 69.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Doa Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>at Joy Place</u>	
3. NAME OF DECEASED (Type or print) <u>Lee Evelyn C. Brown</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-41</u>
9. AGE (In years, lost birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>25</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	
11. BIRTHPLACE (State or foreign country) <u>Robeson County, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willie Christian</u>		14. MOTHER'S MAIDEN NAME <u>Lucille Small</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. Willie Christian, Laurinburg, N.C.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO (b) <u>8254</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>4-10</u> 19 <u>67</u> p.m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 7</u>		20f. (City or town) (County) (State) <u>Hartford Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Beltin</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) <u>556 Lewis Street</u>		Address (Street, city, town, or county) <u>4-10-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 16, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Maxton N.C.</u>	
24. FUNERAL DIRECTOR <u>Elmer E. Ballou</u>		25. REC'D BY REGISTRAR <u>APR 13 1967</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05192

CERTIFICATE OF DEATH

05190

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAVER DE GRACE D.O.A.</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAVER DE GRACE MD</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HARFORD Memorial Hospital</b>				d. STREET ADDRESS <b>Rt. 155 STAR Route</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James HERMAN Clow</b>				4. DATE OF DEATH Month Day Year <b>April 26 1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR. 6 1909</b>	
9. AGE (in years last birthday) <b>58</b> yrs.		10. FUND 1 YEAR Months Days <b>58</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR PEOPLE PERSONNEL</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PA.</b>	
13. FATHER'S NAME <b>JAMES H. CLOW SR.</b>				14. MOTHER'S MAIDEN NAME <b>EMILY VIOLA SARIVER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214-33-2042</b>		17. INFORMANT <b>Mrs. DOLLY R. CLOW, HAVER DE GRACE MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Atherosclerotic Heart Dis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Atherosclerosis &amp; Ischemia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>9 hr</b> <b>8 yr.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State) <b>HAVER DE GRACE MD</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>11-12-62</b> , 19 <b>62</b> , to <b>4-26-1967</b> , that (I) (we) last saw the deceased alive on <b>April 16, 1967</b> , and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Peter P. Rodman, M.D.</b>				22b. DATE SIGNED <b>4-27-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Peter P. Rodman, M.D.</b>				22d. ADDRESS <b>Abertown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>APRIL 28 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUDERSVILLE CEM.</b>	
23d. LOCATION (City, town or county) (State) <b>SUDERSVILLE MD</b>							
24. FUNERAL DIRECTOR <b>R. Madison Mitchell</b>				24a. ADDRESS <b>HAVER DE GRACE, MD.</b>		25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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James H. Glavin  
Director, Federal Bureau of Investigation  
U. S. Department of Justice  
Washington, D. C.  
May 1, 1967  
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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05193

05191

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN lb <u>27 MONTHS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rte 1</u>		d. STREET ADDRESS <u>309 S. Main St</u>	
3. NAME OF DECEASED (Type or print) <u>Olive M. Cullum</u>		4. DATE OF DEATH <u>April 5 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 16, 1910</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>STREET, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>ARCHER W. CULLUM</u>		14. MOTHER'S MAIDEN NAME <u>LAVINIA BULL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>25-32-285</u>	
17. INFORMANT <u>Mrs. VERNON SMITH, STREET, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Breast with Metastases</u> DUE TO (b) <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>4-5-67</u>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APR. 8, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>DUBLIN SOUTHERN</u>		23d. LOCATION (City or Town) (County) (State) <u>DUBLIN, HARTFORD, Md.</u>	
FUNERAL DIRECTOR <u>John H. Harkins, DELTA, PA.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>APR 10 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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OLIVE A. COLLINS

F. W.

HOUSEWOMAN

ANNE W. COLLINS

No

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05194

## CERTIFICATE OF DEATH

05192

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harpe-de-Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Perryville</i>	
c. LENGTH OF STAY IN 1b <i>33 hrs.</i>		d. STREET ADDRESS <i>Susquehanna Ave</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Addie Virginia Cunningham</i>		4. DATE OF DEATH Month <i>4</i> Day <i>9</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 4, 1881</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward</i>		14. MOTHER'S MAIDEN NAME <i>Martha Dye</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>No</i> (If yes give war or dates of service) <i>-----</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mrs. Helen C. Gillespie, Perryville, Md.</i>		Address <i>-----</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO <i>4201</i> (b) <i>A.S.C.V.D</i> DUE TO <i>old age</i> (c) <i>old age</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>-----</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>13</i>	20f. (City or town) <i>4-9</i> (County) <i>67</i> (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4-1</i> , 19 <i>67</i> , to <i>4-9</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4-9</i> , 19 <i>67</i> , and that death occurred at <i>9:30</i> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <i>John D. Yuen</i>		22b. DATE SIGNED <i>4/10/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>John D. Yuen</i>		22d. ADDRESS <i>Harpe de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>April 12, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Asbury Cemetery</i>	23d. LOCATION (City or Town) <i>Port Deposit, Maryland.</i> (County) (State)
24. FUNERAL DIRECTOR <i>Lee A. Patterson &amp; Son, Perryville, Md.</i>		25a. REC'D BY REGISTRAR <i>APR 17 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Handwritten notes and signatures, including a large signature in the center and various smaller notes and initials.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05195

05193

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Grace</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Queens</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Astoria Long Island 693</u> d. STREET ADDRESS <u>33-03 24<sup>th</sup> Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIE Elizabeth Dolan</u>		4. DATE OF DEATH Month Day Year <u>April 20 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Billing Dept. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Motors</u>	11. BIRTHPLACE (County & State, or foreign country) <u>New York City, N.Y.</u>
13. FATHER'S NAME <u>John Berrill (D)</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Flynn (D)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>050-22-4367</u>	
17. INFORMANT <u>James Dolan</u>		Address <u>same as 2 C &amp; D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bleeding Esophageal Varices</u> 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of the liver - portal</u> c) <u>hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>7</u> <u>36 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from <u>18 April</u> , 19 <u>67</u> , to <u>20 April</u> , 19 <u>67</u> , that (if (we) last saw the deceased alive on <u>APR 20</u> 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>W. H. Sadowsky</u>		22b. DATE SIGNED <u>4/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. SADOWSKY</u>		22d. ADDRESS <u>504 Lewis St. Hamlet, N.Y.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>21 Apr. 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Long Island City, N.Y.</u>	
24. FUNERAL DIRECTOR <u>William Macomber Sr.</u>		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. [unclear]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05196

CERTIFICATE OF DEATH

05194

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Street</u> <u>12-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>RD 2 Box 330</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>LESHIE</u> Last <u>EPPErley</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. CDOLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26, 1910</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beverage</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pilot, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Posey Everett Epperley</u>				14. MOTHER'S MAIDEN NAME <u>Arinda Claradel Hall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-18-5214</u>		17. INFORMANT <u>RD 2 Address Box 330 Clara M. Epperley Street, Md. 21154</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis, recurrent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>2-3 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 2nd, 1967</u> to <u>April 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 18th, 1967</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>				22b. DATE SIGNED <u>4/18/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Haure de Grace, Ind.</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/21/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nazarene</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air, Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles E. Kurtz Jarrettville, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Box 330

Leslie

June 26, 1910

Truck driver, Haverham, Mass.

Armed Criminal Unit

Postmaster General

Box 330, Forest, Md. 21154

to

*Handwritten signature/initials*

*Handwritten notes and signatures*

Box 330, Forest, Md.

Postmaster General

Charles F. Smith, Haverham, Mass.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05197

## CERTIFICATE OF DEATH

05195

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u> d. STREET ADDRESS <u>351 Wilson St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>RATHER Marie S Perwood</u> First Middle Last				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>29</u> Year <u>1967</u>			
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10/2/1911</u> <b>9. AGE</b> (In years lost birthday) <u>55</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>W. Va.</u>			
<b>13. FATHER'S NAME</b> <u>Peter Paul Cusick</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Heary</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>unk.</u>		<b>17. INFORMANT</b> <u>Frank Perwood</u> Address <u>411 Major Drive, Pikesville, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive and Arteriosclerotic</u> DUE TO (c) <u>Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>443X</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town) (County) (State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4-27, 1967</u> <b>to</b> <u>4-29, 1967</u> <b>that (I) (we) lost saw the deceased alive on</b> <u>4-29, 1967</u> <b>and that death occurred at</b> <u>8:10 P.M.</u> <b>from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Edward C. Loo</u> M.D.				<b>22b. DATE SIGNED</b> <u>4/30/67</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Edward C. Loo, M.D.</u>				<b>22d. ADDRESS</b> <u>Harre de Grace, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>23b. DATE THEREOF</b> <u>5/3/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Methodist Cem.</u>			
<b>23d. LOCATION</b> (City or town) (County) (State) <u>Forest Hill, Md.</u>		<b>24. FUNERAL DIRECTOR</b> <u>Barrymore Cem. Harre de Grace, Md.</u> ADDRESS					
<b>25a. REC'D BY REGISTRAR</b> <u>MAY 3 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

05196

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FOREST HILL</u>	
c. LENGTH OF STAY IN 1b <u>7 DAYS</u>		d. STREET ADDRESS <u>Chestnut Hill Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MORRIS</u> First Middle Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 13, 1980</u>
9. AGE (In years last birthday) <u>Y6</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>FOREST HILL, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PARKER L. FORWOOD</u>		14. MOTHER'S MAIDEN NAME <u>JULIA SMITHSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MARVYN E. FORWOOD, DELTA, PA.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiac Decompensation</u> 4221 DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>2-3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 28, 1967</u> , to <u>APRIL 3, 1967</u> that (I) (we) last saw the deceased alive on <u>APRIL 3, 1967</u> , and that death occurred at <u>10:04 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Fox, M.D.</u>		22b. DATE SIGNED <u>4/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Fox, M.D.</u>		22d. ADDRESS <u>Haure de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APR. 5, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>DEER CREEK METHODIST</u>		23d. LOCATION (City or Town) (County) (State) <u>CHESTNUT HILL, HARFORD, MD.</u>	
24. FUNERAL DIRECTOR <u>John N. Harkins, DELTA, PA.</u>		25a. REC'D BY REGISTRAR <u>APR 6 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02150

INSTITUTE OF RESEARCH

02150

1. NAME OF THE INSTITUTION		2. ADDRESS	
3. CITY		4. STATE	
5. COUNTRY		6. POSTAL CODE	
7. PHONE NUMBER		8. TELETYPE	
9. FAX NUMBER		10. E-MAIL ADDRESS	
11. WEBSITE		12. OTHER CONTACT INFORMATION	
13. NAME OF THE DIRECTOR		14. POSITION	
15. NAME OF THE ASSISTANT DIRECTOR		16. POSITION	
17. NAME OF THE SECRETARY		18. POSITION	
19. NAME OF THE ADMINISTRATIVE ASSISTANT		20. POSITION	
21. NAME OF THE FINANCIAL ASSISTANT		22. POSITION	
23. NAME OF THE RESEARCH ASSISTANT		24. POSITION	
25. NAME OF THE STUDENT ASSISTANT		26. POSITION	
27. NAME OF THE LABORATORY ASSISTANT		28. POSITION	
29. NAME OF THE CLERICAL ASSISTANT		30. POSITION	
31. NAME OF THE RECEPTIONIST		32. POSITION	
33. NAME OF THE JANITOR		34. POSITION	
35. NAME OF THE GARDENER		36. POSITION	
37. NAME OF THE DRIVER		38. POSITION	
39. NAME OF THE SECURITY GUARD		40. POSITION	
41. NAME OF THE CLEANER		42. POSITION	
43. NAME OF THE PAINTER		44. POSITION	
45. NAME OF THE ELECTRICIAN		46. POSITION	
47. NAME OF THE PLUMBER		48. POSITION	
49. NAME OF THE CARPENTER		50. POSITION	
51. NAME OF THE MASON		52. POSITION	
53. NAME OF THE ROOFER		55. POSITION	
54. NAME OF THE LANDSCAPER		56. POSITION	
57. NAME OF THE GARDENER		58. POSITION	
59. NAME OF THE FLOWER ARRANGER		60. POSITION	
61. NAME OF THE JEWELRY MAKER		62. POSITION	
63. NAME OF THE HAIR DRESSER		64. POSITION	
65. NAME OF THE MAKEUP ARTIST		66. POSITION	
67. NAME OF THE DRESSMAKER		68. POSITION	
69. NAME OF THE TAILOR		70. POSITION	
71. NAME OF THE SHOE MAKER		72. POSITION	
73. NAME OF THE HAT MAKER		74. POSITION	
75. NAME OF THE BAG MAKER		76. POSITION	
77. NAME OF THE JEWELRY REPAIRER		78. POSITION	
79. NAME OF THE HAIR RESTORER		80. POSITION	
81. NAME OF THE MAKEUP REPAIRER		82. POSITION	
83. NAME OF THE DRESS REPAIRER		84. POSITION	
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87. NAME OF THE SHOE REPAIRER		88. POSITION	
89. NAME OF THE HAT REPAIRER		90. POSITION	
91. NAME OF THE BAG REPAIRER		92. POSITION	
93. NAME OF THE JEWELRY CLEANER		94. POSITION	
95. NAME OF THE HAIR CLEANER		96. POSITION	
97. NAME OF THE MAKEUP CLEANER		98. POSITION	
99. NAME OF THE DRESS CLEANER		100. POSITION	
101. NAME OF THE TAILOR CLEANER		102. POSITION	
103. NAME OF THE SHOE CLEANER		104. POSITION	
105. NAME OF THE HAT CLEANER		106. POSITION	
107. NAME OF THE BAG CLEANER		108. POSITION	
109. NAME OF THE JEWELRY POLISHER		110. POSITION	
111. NAME OF THE HAIR POLISHER		112. POSITION	
113. NAME OF THE MAKEUP POLISHER		114. POSITION	
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121. NAME OF THE HAT POLISHER		122. POSITION	
123. NAME OF THE BAG POLISHER		124. POSITION	
125. NAME OF THE JEWELRY ENGRAVER		126. POSITION	
127. NAME OF THE HAIR ENGRAVER		128. POSITION	
129. NAME OF THE MAKEUP ENGRAVER		130. POSITION	
131. NAME OF THE DRESS ENGRAVER		132. POSITION	
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137. NAME OF THE HAT ENGRAVER		138. POSITION	
139. NAME OF THE BAG ENGRAVER		140. POSITION	
141. NAME OF THE JEWELRY DESIGNER		142. POSITION	
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155. NAME OF THE BAG DESIGNER		156. POSITION	
157. NAME OF THE JEWELRY REPAIRER		158. POSITION	
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427. NAME OF THE BAG CLEANER		428. POSITION	
429. NAME OF THE JEWELRY POLISHER		430. POSITION	
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443. NAME OF THE BAG POLISHER		444. POSITION	
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447. NAME OF THE HAIR ENGRAVER		448. POSITION	
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451. NAME OF THE DRESS ENGRAVER		452. POSITION	
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457. NAME OF THE HAT ENGRAVER		458. POSITION	
459. NAME OF THE BAG ENGRAVER		460. POSITION	
461. NAME OF THE JEWELRY DESIGNER		462. POSITION	
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469. NAME OF THE TAILOR DESIGNER		470. POSITION	
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475. NAME OF THE BAG DESIGNER		476. POSITION	
477. NAME OF THE JEWELRY REPAIRER		478. POSITION	
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491. NAME OF THE BAG REPAIRER		492. POSITION	
493. NAME OF THE JEWELRY CLEANER		494. POSITION	
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497. NAME OF THE MAKEUP CLEANER		498. POSITION	
499. NAME OF THE DRESS CLEANER		500. POSITION	
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503. NAME OF THE SHOE CLEANER		504. POSITION	
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507. NAME OF THE BAG CLEANER		508. POSITION	
509. NAME OF THE JEWELRY POLISHER		510. POSITION	
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523. NAME OF THE BAG POLISHER		524. POSITION	
525. NAME OF THE JEWELRY ENGRAVER		526. POSITION	
527. NAME OF THE HAIR ENGRAVER		528. POSITION	
529. NAME OF THE MAKEUP ENGRAVER		530. POSITION	
531. NAME OF THE DRESS ENGRAVER		532. POSITION	
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539. NAME OF THE BAG ENGRAVER		540. POSITION	
541. NAME OF THE JEWELRY DESIGNER		542. POSITION	
543. NAME OF THE HAIR DESIGNER		544. POSITION	
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547. NAME OF THE DRESS DESIGNER		548. POSITION	
549. NAME OF THE TAILOR DESIGNER		550. POSITION	
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555. NAME OF THE BAG DESIGNER		556. POSITION	
557. NAME OF THE JEWELRY REPAIRER		558. POSITION	
559. NAME OF THE HAIR REPAIRER		560. POSITION	
561. NAME OF THE MAKEUP REPAIRER		562. POSITION	
563. NAME OF THE DRESS REPAIRER		564. POSITION	
565. NAME OF THE TAILOR REPAIRER		566. POSITION	
567. NAME OF THE SHOE REPAIRER		568. POSITION	
569. NAME OF THE HAT REPAIRER		570. POSITION	
571. NAME OF THE BAG REPAIRER		572. POSITION	
573. NAME OF THE JEWELRY CLEANER		574. POSITION	
575. NAME OF THE HAIR CLEANER		576. POSITION	
577. NAME OF THE MAKEUP CLEANER		578. POSITION	
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585. NAME OF THE HAT CLEANER		586. POSITION	
587. NAME OF THE BAG CLEANER		588. POSITION	
589. NAME OF THE JEWELRY POLISHER		590. POSITION	
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667. NAME OF THE BAG CLEANER		668. POSITION	
669. NAME OF THE JEWELRY POLISHER		670. POSITION	
671. NAME OF THE HAIR POLISHER		672. POSITION	
673. NAME OF THE MAKEUP POLISHER		674. POSITION	
67			



05199

## CERTIFICATE OF DEATH

05197

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY in 1b <i>3 mo.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Brevin Nursing Home</i>		d. STREET ADDRESS <i>Perryville</i>	
3. NAME OF DECEASED (Type or print) First <i>Naomi</i> Middle <i>K.</i> Last <i>Fouche</i>		4. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>67</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cau.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 31, 1897</i>
9. AGE (In years last birthday) <i>69</i> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Kelly</i>		14. MOTHER'S MAIDEN NAME <i>Clara McMullen</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>219-05-7793</i>	
17. INFORMANT <i>Miss Ethel Taylor, Perryville, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Sclerosis -</i> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerosis -</i> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>2 mos -</i> <i>5 yrs -</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arterio Sclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 20, 1964</i> to <i>April 29, 1967</i> , that (I) (we) lost saw the deceased alive on <i>April 28, 1967</i> , and that death occurred at <i>11:20 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Clarence I. Benson</i>		22b. DATE SIGNED <i>4/29/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Clarence I. Benson</i>		22d. ADDRESS <i>Port Deposit, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 2, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Asbury Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Port Deposit, Cecil, Md.</i>	
24. FUNERAL DIRECTOR <i>Lee A. Patterson &amp; Son, Perryville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>3 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

50120

02160

05200

## CERTIFICATE OF DEATH

05198

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE de Grace</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE de Grace</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>623 N. Stokes St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alonza</u> Middle <u>Byer</u> Last <u>Frederick</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/18/1897</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Municipal Utilities</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harde Chase, Md.</u>	
13. FATHER'S NAME <u>John N. Frederick (de)</u>				14. MOTHER'S MAIDEN NAME <u>Maudie M. Walker (de)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>+</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT <u>Wilbur Frederick</u> Address <u>623 N. Stokes St. Harde Chase, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Interseptal Myocardial infarction, secondary</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular</u> DISEASE (c) <u>Disease</u>							INTERVAL BETWEEN ONSET AND DEATH: <u>2-3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cirrhosis of the liver</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1st, 1967</u> to <u>April 2, 1967</u> that (I) (we) last saw the deceased alive on <u>April 2, 1967</u> , and that death occurred at <u>11P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Too, M.D.</u>				22b. DATE SIGNED <u>4/3/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Too, M.D.</u>				22d. ADDRESS <u>Havre de Grace, Ind.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Harde Chase, Md.</u>	
24. FUNERAL DIRECTOR <u>Lawrence R. Harde Chase, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

02128

02500

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY, N. Y.

CERTIFICATE OF DEED

IN SENATE, JANUARY 1, 1901.

AND IN ASSEMBLY, JANUARY 1, 1901.

AND IN SENATE, JANUARY 1, 1901.

AND IN ASSEMBLY, JANUARY 1, 1901.

AND IN SENATE, JANUARY 1, 1901.

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AND IN ASSEMBLY, JANUARY 1, 1901.

AND IN SENATE, JANUARY 1, 1901.

AND IN ASSEMBLY, JANUARY 1, 1901.

AND IN SENATE, JANUARY 1, 1901.

05201

## CERTIFICATE OF DEATH

05199

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>419 Baltimore Street</b>		d. STREET ADDRESS <b>419 Baltimore Street</b>	
3. NAME OF DECEASED (Type or print) First <b>AQUILLA</b> Middle <b>FRISBY</b> Last <b>FRISBY</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1897</b>
9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months <b>12</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>12</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) <b>Custodian (Ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office Dept. Harford County, Md.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>George Frisby (D)</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Green</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW-I</b>		16. SOCIAL SECURITY NO. <b>219-05-0930</b>	
17. INFORMANT <b>Hazel Frisby, Aberdeen Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ASHD</b> DUE TO (c) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b> <b>YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>DEC. 1966</b> to <b>APRIL 1967</b> , that (I) (we) lost saw the deceased alive on <b>4/14 1967</b> , and that death occurred at <b>8:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Santiago Leyte-Vidal</i>		22b. DATE SIGNED <b>4/25/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Santiago Leyte-Vidal M.D.</b>		22d. ADDRESS <b>114 W. Bel Air, Aberdeen, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>27 April 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Aberdeen, Maryland</b>
24. FUNERAL DIRECTOR <i>Walter Macomber Jr.</i>		25a. REC'D BY REGISTRAR <b>Tarring Funeral Home</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <b>APR 27 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02130



05202

## CERTIFICATE OF DEATH

05200

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Three-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
c. LENGTH OF STAY IN 1b <u>17 hrs.</u>		d. STREET ADDRESS <u>R.D. # 3</u>	
3. NAME OF DECEASED (Type or print) <u>Mamie Ramsey Gregg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH <u>4</u> Month <u>6</u> Day <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>84</u> yrs.
9. IF UNDER 1 YEAR Months Days Hours Min.		10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Ramsey</u>		14. MOTHER'S MAIDEN NAME <u>Allie Ewing</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Wilhelmina Gregg (Son)</u>		Address <u>-----</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia of right upper &amp; lower lobes</u> DUE TO (b) <u>-----</u> DUE TO (c) <u>-----</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>490X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized atherosclerosis + A.S.C.V.D. + CVA.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-5</u> , 19 <u>67</u> to <u>4-6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/6</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/6/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Three-de-Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moore's Chapel Cemetery, Blake, Cecil Co. Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Hicks Home for Funerals, Elkton, Md.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

05200

CERTIFICATE OF DEATH

1982

Nov. 6, 1982

Domestic

DIVISION

NOV 10 1982

Funeral Home for Funerals, Winston, N.C.

Funeral Home for Funerals, Winston, N.C.

05203

## CERTIFICATE OF DEATH

05201

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>139 MAULSBY AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER JAMES HASH, JR.</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 4 1967</u>
9. AGE (In years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTER JAMES HASH</u>		14. MOTHER'S MAIDEN NAME <u>MARY EVELYN MCGREENY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT (Father) <u>Mr. Walter James Hash</u>		Address <u>139 Maulsby St. Bel Air, Maryland 21014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Edema</u> <u>760.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhage from pt. arterial tear</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 4, 1967</u> , to <u>APRIL 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>APRIL 7, 1967</u> , and that death occurred at <u>9:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>J. Foster</u>		22b. DATE SIGNED <u>4/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph William Foster</u>		22d. ADDRESS <u>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 8, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		23d. LOCATION (City or Town) (County) (State) <u>BEL AIR, HARFORD CO., MARYLAND</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		24. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05204

05202

1. PLACE OF DEATH a. COUNTY <u>Harford County</u> <u>Harford de Grace</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Chesapeake</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Market &amp; Ker. St Harford de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville, Md</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Reservoir Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>L. H. Hornberger</u>		4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/73</u>
9. AGE (In years last birthday) yrs. <u>93</u>		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>10</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry M. Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Smeltzer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Medicare # 220-6-2400 T</u>	
17. INFORMANT <u>Paul A. Patterson, Perryville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>4/24/67</u> , 19 <u>67</u> , to <u>4/26/67</u> , 19 <u>67</u> , that (2) (we) lost saw the deceased alive on <u>4/26/67</u> 19 <u>67</u> , and that death occurred at <u>11:02</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Chas. G. Grigoleit MD</u>		22b. DATE SIGNED <u>4/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. W. GRIGOLEIT MD</u>		22d. ADDRESS <u>HARVEY de GRACE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Patterson Fam. Burial Gps. Perryville, Md.</u>	23d. LOCATION (City or Town) (County) (State) <u>Cecil</u>
24. FUNERAL DIRECTOR <u>Paul A. Patterson &amp; Son, Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

VR A15 (4)  
25M 1/67

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05203					05203						
1. PLACE OF DEATH a. COUNTY <b>Harford</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b>			c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kirk Army Hospital</b>					d. STREET ADDRESS <b>1001 Old Joppa Road</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>William</b>		Middle <b>H. B.</b>		Last <b>HOWARD</b>		4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>18 February 1904</b>		9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>63</b> Days <b>13</b> Hours <b>2</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Army</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore County, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Benjamin C. Howard</b>					14. MOTHER'S MAIDEN NAME <b>Katherine Browne</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>1942 - 1959</b>		17. INFORMANT <b>Wife</b>		Address <b>(same as above)</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left intracerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>6 April</b> , 19 <b>67</b> , to <b>9 April</b> , 19 <b>67</b> , that <del>XX</del> (we) last saw the deceased alive on <b>9 April</b> , 19 <b>67</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Harold C. Sheaffer</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9 April 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>HAROLD C. SHEAFFER, MAJ, MC</b>						22d. ADDRESS <b>Kirk Army Hospital, Aberdeen PG, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Apr 12 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington</b>			23d. LOCATION (City, town or county) (State) <b>Arlington Va</b>			
24. FUNERAL DIRECTOR <b>W. H. Archer</b>						ADDRESS <b>Benson, Md</b>		25a. REC'D BY REGISTRAR <b>APR 13 1967</b>			
								25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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## CERTIFICATE OF DEATH

05204

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Chester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE de GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural - Nottingham</u> 75-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		d. STREET ADDRESS <u>R. 19.2.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 22 1891</u> 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>W. Nottingham-Twp. Pa.</u>	
13. FATHER'S NAME <u>Samuel Grason</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-8933</u>	
17. INFORMANT <u>Lewis F. Jones</u>		Address <u>Nottingham R.D. 2. Pa</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiogenic heart failure</u> DUE TO (c) <u>A.S.C.V.D</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> , 19 <u>67</u> , to <u>4-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 10</u> 19 <u>67</u> , and that death occurred at <u>4:15</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>John D. Y...</u>		22b. DATE SIGNED <u>4/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. Y...</u>		22d. ADDRESS <u>Havre de Grace, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Apr. 14 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nottingham Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Nottingham, Chester Pa</u>
24. FUNERAL DIRECTOR <u>RALPH M REED</u>		25a. REC'D BY REGISTRAR <u>APR 12 1967</u>	
ADDRESS <u>Rising Sun, M.D.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05207					05205				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>HARFORD</u> MARYLAND					a. STATE <u>MASS.</u> b. COUNTY <u>✓</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pittsfield</u> 513				
c. LENGTH OF STAY IN 1b <u>D.O.A</u>					d. STREET ADDRESS <u>95 Daniels Ave</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>E.</u> Last <u>Kelleen</u>					4. DATE OF DEATH Month <u>APRIL</u> Day <u>29</u> Year <u>1967</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-1906</u>		9. AGE (in years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Club Steward</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Kelleen</u>					14. MOTHER'S MAIDEN NAME <u>Theresa UNKNOWN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>					16. SOCIAL SECURITY NO. <u>314-18-3973</u>				
					17. INFORMANT <u>ENGELICA Kelleen Pittsfield, Mass.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>									
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>Coronary Vascular Disease</u>									
(c) <u>hypertensive cardiac sclerosis</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April 29</u> , 19 <u>67</u> , to <u>April 29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 29</u> , 19 <u>67</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Edward J. Simon</u>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>EDWARD J. SIMON</u>					22d. ADDRESS <u>Home De Grace, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>5-7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Havening Chapel</u>		23d. LOCATION (City, town or county) (State) <u>Pittsfield, Mass. MA</u>		
24. FUNERAL DIRECTOR <u>James J. O'Hara, New York, N.Y.</u>					25a. REC'D BY REGISTRAR <u>3</u> 1967				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

02302

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05208

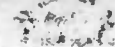
CERTIFICATE OF DEATH

05206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		121	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>BAYOU VILLA, APT 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM SCARFF Kelly</u>				4. DATE OF DEATH Month Day Year <u>APRIL 3 1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 24, 1987</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier in Garden Wacky, Calif.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EDGAR C. KELLY</u>				14. MOTHER'S MAIDEN NAME <u>JEANETTE SCARFF</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>550-07-6749</u>		17. INFORMANT <u>ANNIE W. KELLY</u> APT. 1A Address <u>BAYOU VILLA HAVER DE GRACE, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>1221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 5th, 1966</u> , to <u>APRIL 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>APRIL 3, 1967</u> , and that death occurred at <u>7:35 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Loc, M.D.</u>				22b. DATESIGNED <u>4/3/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loc, M.D.</u>	
22d. ADDRESS <u>HAVER DE GRACE, MD.</u>				22e. REC'D BY REGISTRAR <u>APR 6 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APR. 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>HAVER DE GRACE, MD.</u>	
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>				25a. REC'D BY REGISTRAR <u>APR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



02508

CERTIFICATE OF DEATH

02508

Name of Deceased				Date of Birth			
Sex				Race			
Marital Status				Occupation			
Cause of Death				Place of Death			
Time of Death				Signature of Physician			
Signature of Registrar				Date of Registration			
Place of Registration				Official Seal			

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE NATIONAL BUREAU OF VITAL STATISTICS AND RECORDS, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, UNITED STATES OF AMERICA.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05207**

**05203**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEL AIR (RURAL)</b>		c. LENGTH OF STAY IN 1b <b>8 MOS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARF. CONVAL. HOME</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKS (RURAL 21141)</b>	
f. STREET ADDRESS <b>KNOPP Rd</b>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>LUELLA</b> Last <b>KNOPP</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 13, 1880</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>7</b>	11. IF UNDER 24 HRS. Hours <b>12</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY J. HORN</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE C. OBITS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-24-5557</b>	
17. INFORMANT <b>AARON KNOPP</b>		18. ADDRESS <b>OLD FEDERAL HILL ROAD ROCKS, MD 21141</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b> (a), stating the underlying cause lost. DUE TO <b>OVER 10 YRS</b> (c) <b>1 YR</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS, PHYSIOLOGIC FRACTURE RT HIP</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>RT HIP TURNING IN BED DURING NIGHT</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>FEB 28 1967</b> p. m. <b>NIGHT</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME, HARF. CONVAL.</b>		20f. (City or town) (County) (State) <b>DEL AIR, HARFORD, MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Philip W. Heuman</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>DEL AIR, MD.</b>	
EXAMINER'S NAME (Type) <b>PHILIP W. HEUMAN, M.D.</b>		DATE SIGNED <b>APRIL 1, 1967</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/4/1967</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WILLIAM WATERS</b>	22d. LOCATION (City, town, or county) (State) <b>COOPTOWN MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHARLES E. KURTZ</b>		ADDRESS <b>JARRETTVILLE, MD.</b>	
24a. REC'D BY REGISTRAR <b>APR 4 1967</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kurtz</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

21084

02507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02507

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Death: 10-15-1960

5. Place of Death: Home

6. Cause of Death: Myocardial Infarction

7. Manner of Death: Natural

8. Signature of Medical Examiner: [Signature]

9. Date of Examination: 10-15-1960

10. Location of Examination: Home

11. Name of Physician: Dr. J. Smith

12. Address of Physician: 123 Main St.

13. City: New York

14. State: NY

15. Zip: 10001

16. Name of Coroner: John Doe

17. Address of Coroner: 456 Main St.

18. City: New York

19. State: NY

20. Zip: 10001

21. Name of Medical Examiner: Dr. J. Smith

22. Address of Medical Examiner: 789 Main St.

23. City: New York

24. State: NY

25. Zip: 10001

26. Name of Hospital: St. Mary's

27. Address of Hospital: 101 Main St.

28. City: New York

29. State: NY

30. Zip: 10001

31. Name of Funeral Home: ABC

32. Address of Funeral Home: 201 Main St.

33. City: New York

34. State: NY

35. Zip: 10001

36. Name of Burial Place: St. Mary's

37. Address of Burial Place: 101 Main St.

38. City: New York

39. State: NY

40. Zip: 10001

41. Name of Cemetery: St. Mary's

42. Address of Cemetery: 101 Main St.

43. City: New York

44. State: NY

45. Zip: 10001

46. Name of Interment: St. Mary's

47. Address of Interment: 101 Main St.

48. City: New York

49. State: NY

50. Zip: 10001

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05210

05208

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b> 121			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital - DOA</b>				d. STREET ADDRESS <b>2304 Willoughby Beach Road</b>			
3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> Middle <b>LILLIAN</b> Last <b>LANTZ</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>23</b> Year <b>1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 6, 1890</b>	
9. AGE (In years last birthday) yrs. <b>76</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Bradshaw, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Leonard Knight</b>				14. MOTHER'S MAIDEN NAME <b>Angeline Ocelia Greenland</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-36-8900</b>		17. INFORMANT <b>Helen B. Lantz, 2304 Willoughby Beach Road</b> Address <b>Edgewood, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C V Disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural</b> causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Gerald C Palmer</b> M.D.				22. DATE SIGNED <b>April 24, 1967</b>			
EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 26, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Joppa Harford Md</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md. 21009</b>				25a. REC'D BY REGISTRAR <b>APR 26 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

05208

05208



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05211					05209				
Item #14 Infor. taken from birth cert.									
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hare de Grace</u>			c. LENGTH OF STAY IN 1b <u>36 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u> , <u>121</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>					d. STREET ADDRESS <u>Box 94</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl "B"</u> First Middle Last					4. DATE OF DEATH <u>APRIL 27</u> 19 <u>67</u> Month / Day Year				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-25-67</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>12</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Larry Randolph LAWSON</u>					14. MOTHER'S MAIDEN NAME <u>Mary Estella HAMPTON</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT (Printed Name) <u>Mr. Larry R. Lawson</u> Address <u>Box #94 Churchville Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>7735</u> IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Respiratory Distress Syndrome</u> DUE TO (c) <u>Hyaline Membrane Disease</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>PREMATURITY</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April 25</u> , 19 <u>67</u> , to _____, 19____, that (I) (we) last saw the deceased alive on <u>April 27</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Alonso Gomez</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/27/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>ALONSO GOMEZ</u>					22d. ADDRESS <u>419 S. Union Ave - Hare de Grace</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>April 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air Harford Co., Maryland 21014</u>		
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway &amp; Williams St Bel Air, Maryland 21014</u>					25a. REC'D BY REGISTRAR <u>MAY 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

02300

02311

Regimental Signal Squadron  
Regimental Band  
Regimental Engineer Squadron

1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05212					05210				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>HARFORD</u> MARYLAND					a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURGO GRACE</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u> 12.1				
c. LENGTH OF STAY IN 1b <u>3 days</u>					d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. SEX		
First Middle Last <u>William Wilson Lee</u>					Month Day Year <u>APRIL 15 1967</u>		Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		
6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 7, 1883</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auctioneer</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Addison W. Lee</u>					14. MOTHER'S MAIDEN NAME <u>ELLA P. McCann</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>218-32-1794</u>		17. INFORMANT Address <u>Mrs. H.F. Anthony, Jr., Darlington, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO <u>ARTERIOsclerosis AND Unregulated HT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>failure</u> DUE TO (c) <u>failure</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonitis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>67</u> , to <u>APRIL 15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>APRIL 15</u> , 19 <u>67</u> , and that death occurred at <u>11:45</u> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Dudley Phillips</u>					22b. DATE SIGNED <u>4/16/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>		
22d. ADDRESS <u>Darlington, Md.</u>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>APR. 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Darlington</u>		23d. LOCATION (City, town or county) (State) <u>Darlington, Md.</u>		
24. FUNERAL DIRECTOR <u>John H. Harkin, Delta, Pa.</u>					25a. REC'D BY REGISTRAR <u>APR 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

02519

02519

1958

W. J. P. 1958

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W. J. P. 1958

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W. J. P. 1958

W. J. P. 1958

W. J. P. 1958

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 9M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05213

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05211

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Coshocton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Proving Ground</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coshocton</u> 72-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kirk Army Hospital DOA</u>		d. STREET ADDRESS <u>Route #4</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stanley Lewis</u>		4. DATE OF DEATH Month Day Year <u>April 15 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>14 June 1915</u>
9. AGE (In years last birthday) yrs. <u>51</u>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Labor</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW-II</u>		16. SOCIAL SECURITY NO. <u>274-12-2158</u>	
17. INFORMANT <u>Dawson Funeral Home, Ohio</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coxsackery bedulusion</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>16 April 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Prairie Chapel Cemetery, Coshocton</u>		23d. LOCATION (City or Town) (County) (State) <u>Ohio</u>	
24. FUNERAL DIRECTOR <u>Tarring Funeral Home, Aberdeen, Md.</u>		25a. REC'D BY REGISTRAR <u>April 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22. DATE SIGNED <u>4-15-67</u> <u>Bel Air, Md.</u>	

11520

11521



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
05214					05212					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <b>Harford</b> MARYLAND					a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Abingdon</b> 121					
c. LENGTH OF STAY IN 1b <b>4 Days</b>					d. STREET ADDRESS <b>4228 Birch Avenue</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kirk Army Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last <b>Charles LEONARD LINDSEY Jr.</b>					Month Day Year <b>April 24 1967</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 April 1967</b>		9. AGE (In years last birthday) yrs. <b>4</b> IF UNDER 1 YEAR Months <b>4</b> IF UNDER 24 HRS. Hours <b>4</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harford, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Charles L. Lindsey</b>					14. MOTHER'S MAIDEN NAME <b>Murphy Patricia Murphy</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Father (Same as above)</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity - hyaline membrane pulmonary disease</b> <b>7735</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>physiologic jaundice</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>21 April</b> , 19 <b>67</b> , to <b>24 April</b> , 19 <b>67</b> , that <del>he</del> (we) last saw the deceased alive on <b>24 April</b> , 19 <b>67</b> , and that death occurred at <b>540 PM</b> , from the causes and on the date stated above.										
22a. SIGNATURE <i>Leland Wight</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>25 April 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>LELAND WIGHT, CPT, MC</b>					22d. ADDRESS <b>Kirk Army Hospital, APG, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 27, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		23d. LOCATION (City, town or county) (State) <b>Bel Air Harford Co, Maryland 21014</b>				
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>					ADDRESS <b>W. Broadway &amp; Williams St Bel Air, Maryland 21014</b>		25a. REC'D BY REGISTRAR <b>APR 27 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

05212

05212

W. J. H. H. H.

Maryland

Hartford

Admission Proving Ground

4 days

Admission

With Army Hospital

Admission Proving Ground

Admission Proving Ground

Admission Proving Ground

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Admission Proving Ground

05215

## CERTIFICATE OF DEATH

05213

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Harford</u>	
a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harle de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XXXXXXXXXXXX Aberdeen,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>		d. STREET ADDRESS <u>Rd 3</u>	
3. NAME OF DECEASED (Type or print) <u>Emil</u>		4. DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Sept. 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE (In years lost birthday) yrs. <u>60</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Karl Mackovi</u>		14. MOTHER'S MAIDEN NAME <u>Cecilie Kundrahy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>217-14-3768</u>	
17. INFORMANT <u>Alphonse J. Hostinek, Baltimore Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>A.S.C.V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 20, 1961</u> to <u>April 6th, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 6th, 1967</u> , and that death occurred at <u>2:10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>4/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harle de Grace, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8 April 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Perryman (Harford) Md.</u>
24. FUNERAL DIRECTOR <u>Wilhelmina Macomber Sr.</u>		25. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>	
ADDRESS <u>Aberdeen, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

E1320

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1980

# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05216

05214

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>		c. LENGTH OF STAY IN lb <b>16 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>--</b>			d. STREET ADDRESS <b>335 McCann Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>VIRGIN</b> Middle <b>EDITH</b> Last <b>McDANIEL</b>			4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1899</b>		9. AGE (In years lost birthday) yrs. <b>68</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William E. Hunter</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Thompson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mrs. Jewell B. Dudley, 335 McCann St. Edgewood Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C V disease</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE: <b>Gerald C. Palmer</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>Bel Air, Md.</b>		22. DATE SIGNED <b>4-13-67</b>	
EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>Bel Air, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 15, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Bel Air Harford Md</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>			25a. REC'D BY REGISTRAR <b>APR 14 1967</b>		
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

02315

02315

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05217					05215				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>HARFORD</u> MARYLAND					a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>JOPPA</u>				
c. LENGTH OF STAY IN 1b <u>59 days</u>					d. STREET ADDRESS <u>200 Fitzhugh Rd</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA Lucille Mc HENRY</u>					4. DATE OF DEATH Month Day Year <u>APRIL 22 1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 28-1899</u>		9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Work</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Boyd Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <u>Henry Howell</u>					14. MOTHER'S MAIDEN NAME <u>Mary Connelly</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>261-10-0378</u>				
17. INFORMANT <u>Ms. Woodard Bartlett</u>					Address <u>200 Fitzhugh Rd.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, extensive</u> 4201 DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>2 years</u> (c) <u>3 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myelonephritis, Hypothyroidism, Fatty Degeneration of liver</u>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 23, 1967</u> , to <u>April 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>APRIL 22, 1967</u> , and that death occurred at <u>5:30 M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Edward C. Lee, M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <u>4/22/67</u>									
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u> ADDRESS <u>HAVERDE GRACE, MD.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/26/67</u>									
23b. DATE THEREOF									
23c. NAME OF CEMETERY OR CREMATORY <u>Riverside Mem. Park</u>									
23d. LOCATION (City, town or county) (State) <u>Homerton Phila. Pa.</u>									
24. FUNERAL DIRECTOR <u>Charles J. ...</u> ADDRESS <u>...</u>									
25a. REC'D BY REGISTRAR <u>APR 25 1967</u>									
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05218

## CERTIFICATE OF DEATH

05216

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVRE de GRACE</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				e. STREET ADDRESS <u>109 Van Diver Ct.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William FRAZIER McMillion</u>				4. DATE OF DEATH Month Day Year <u>April 13 1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/29/1875</u>	9. AGE (in years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Esty, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank McMillion</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>176-07-8734</u>		17. INFORMANT <u>Mrs. Ann Gregory</u> Address <u>109 Van Diver Ct. Havre de Grace, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart disease</u> DUE TO (b) <u>Cerebral arterio-sclerosis</u> DUE TO (c) <u>1 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>1 day</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 12, 1967</u> to <u>April 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 13, 1967</u> , and that death occurred at <u>2:25</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Irvin Wachsmen</u>				22b. DATE SIGNED <u>4/13/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Irvin Wachsmen</u>				22d. ADDRESS <u>Havre de Grace, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/15/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fallston Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Fallston, Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles E. Kurtz Jarrettsville, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 17 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

02319

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02319

FOR STATE HEALTH DEPT. M

05219

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05218

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Three de Grace DOR.</u>		c. LENGTH OF STAY IN 1b <u>121</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		d. STREET ADDRESS (Hughes Road) <u>RD 1, Box 80-D</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. 1725 South Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>Monk</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 18, 1939</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Estell Monk</u>		14. MOTHER'S MAIDEN NAME <u>IRENA May Woods</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-36-9902</u>	
17. INFORMANT (Wife) <u>457-4766</u> <u>Mrs. Peggy Y. Monk</u>		Address <u>RD #1, Box # 80-D</u> <u>Darlington, Maryland 21034</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8254</u> DUE TO (c) <u>3</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>4-22</u> p.m. <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Conowingo Bridge Rd</u>		20f. (City or town) (County) (State) <u>Darlington Harford MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air MD.</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-2367</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 26, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>BEL AIR, Harford Co., Maryland 21014</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway &amp; Williams St.</u> <u>BEL AIR, Maryland 21014</u>		25a. REG'D BY REGISTRAR DATE <u>APR 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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05220

## CERTIFICATE OF DEATH

05217

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>		d. STREET ADDRESS <u>Chapel Road</u>	
3. NAME OF DECEASED (Type or print) <u>Hester EARL Meyers</u>		4. DATE OF DEATH <u>April 8 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 19 1902</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. G. Meyers</u>		14. MOTHER'S MAIDEN NAME <u>Laura M. Rogers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES NATIONAL GUARD</u>		16. SOCIAL SECURITY NO. <u>174-10-2919</u>	
17. INFORMANT <u>Rebecca A. Meyers</u>		Address <u>RD #2 Box 67 Haver de Grace Md 21078</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> 2-3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 10th, 1967</u> to <u>April 8, 1967</u> that (I) (we) last saw the deceased alive on <u>April 8th, 1967</u> , and that death occurred at <u>2:10 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/8/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Haver de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HAYS CEM.</u>	23d. LOCATION (City or town) (County) (State) <u>EASTON NORTH PA.</u>
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>		ADDRESS <u>Haver de Grace, Md.</u>	25a. REC'D BY REGISTRAR <u>ANN 13 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0251A

CERTIFICATE OF DEATH

0251A

1. Name of deceased		2. Date of death	
3. Place of death		4. Cause of death	
5. Age at death		6. Sex	
7. Marital status		8. Occupation	
9. Date of birth		10. Place of birth	
11. Name of informant		12. Signature of informant	
13. Name of registrar		14. Signature of registrar	
15. Date of registration		16. Place of registration	
17. Name of medical officer		18. Signature of medical officer	
19. Name of coroner		20. Signature of coroner	
21. Name of registrar		22. Signature of registrar	
23. Name of registrar		24. Signature of registrar	
25. Name of registrar		26. Signature of registrar	
27. Name of registrar		28. Signature of registrar	
29. Name of registrar		30. Signature of registrar	
31. Name of registrar		32. Signature of registrar	
33. Name of registrar		34. Signature of registrar	
35. Name of registrar		36. Signature of registrar	
37. Name of registrar		38. Signature of registrar	
39. Name of registrar		40. Signature of registrar	
41. Name of registrar		42. Signature of registrar	
43. Name of registrar		44. Signature of registrar	
45. Name of registrar		46. Signature of registrar	
47. Name of registrar		48. Signature of registrar	
49. Name of registrar		50. Signature of registrar	
51. Name of registrar		52. Signature of registrar	
53. Name of registrar		54. Signature of registrar	
55. Name of registrar		56. Signature of registrar	
57. Name of registrar		58. Signature of registrar	
59. Name of registrar		60. Signature of registrar	
61. Name of registrar		62. Signature of registrar	
63. Name of registrar		64. Signature of registrar	
65. Name of registrar		66. Signature of registrar	
67. Name of registrar		68. Signature of registrar	
69. Name of registrar		70. Signature of registrar	
71. Name of registrar		72. Signature of registrar	
73. Name of registrar		74. Signature of registrar	
75. Name of registrar		76. Signature of registrar	
77. Name of registrar		78. Signature of registrar	
79. Name of registrar		80. Signature of registrar	
81. Name of registrar		82. Signature of registrar	
83. Name of registrar		84. Signature of registrar	
85. Name of registrar		86. Signature of registrar	
87. Name of registrar		88. Signature of registrar	
89. Name of registrar		90. Signature of registrar	
91. Name of registrar		92. Signature of registrar	
93. Name of registrar		94. Signature of registrar	
95. Name of registrar		96. Signature of registrar	
97. Name of registrar		98. Signature of registrar	
99. Name of registrar		100. Signature of registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05221					05219						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Harford</b>					a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>						
c. LENGTH OF STAY IN 1b <b>39 years</b>					d. STREET ADDRESS <b>(U.S. #1) Bel Air Road</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>(U.S. #1) Bel Air Road</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
<b>Myrtle Florence Neilkirk</b>						<b>April</b>			<b>25, 19 67</b>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<b>Female</b>		<b>White</b>				<b>Oct. 12, 1889</b>		<b>77</b> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harford Co., Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Jacob A. Doxen</b>						14. MOTHER'S MAIDEN NAME <b>Elizabeth Beaumont</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-18-7307</b>		17. INFORMANT (Brother) <b>838-6148</b>			Address <b>Bel Air, Md. 21014</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic CV Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1-1</b> , 19 <b>45</b> , to <b>4-25</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-15</b> , 19 <b>67</b> , and that death occurred at <b>9P.</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Gerald C. Palmer</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 26, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>						22d. ADDRESS <b>S. Main St., Bel Air, Md. 21014</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Apr. 28, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Meth. Ch. Com.</b>			23d. LOCATION (City, town or county) (State) <b>Fountain Green, Harf. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>W. Broadway &amp; Williams St.</b> <b>Bel Air, Maryland 21014</b>						25a. REC'D BY REGISTRAR <b>APK 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05222

05220

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. LENGTH OF STAY IN lb <u>3 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dragon Wagon Trailer Co.</u>		d. STREET ADDRESS <u>538 Trimble Road</u> <u>Dragon Wagon Trailer Co.</u>	
3. NAME OF DECEASED (Type or print) <u>Walter M Niehoff</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
13. FATHER'S NAME <u>Herman Niehoff</u>		14. MOTHER'S MAIDEN NAME <u>Susan Mercer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>218-14-5600</u>	17. INFORMANT <u>Wiley T. Richardson, 1627 Riverwood Rd,</u> Address <u>Baltimore, Md.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> <u>11221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-2267</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>
24. FUNERAL DIRECTOR <u>Howard K. McComas &amp; Son, Abingdon, Md. 21009</u>		25. REC'D BY REGISTRAR DATE <u>APR 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22. DATE SIGNED <u>4-22-67</u>	

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05223

## CERTIFICATE OF DEATH

05221

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Churchville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Churchville</b> 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route #1, Box 466</b>		d. STREET ADDRESS <b>Route #1, Box 466</b>	
3. NAME OF DECEASED (Type or print) First <b>HAROLD</b> Middle <b>A.</b> Last <b>NOBLE JR.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1916</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>10</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technical Director</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dev. &amp; Pr. Svcs.</b> <b>Harold A. Noble Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Edna Snyder</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>511-01-9259</b>	
17. INFORMANT <b>Mrs. Iris Noble, Churchville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Ischemia</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>One hour</b> <b>One hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Atrial fibrillation chronic, Cause undetermined</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-17-1951</b> to <b>2-22-1967</b> that (I) (we) last saw the deceased alive on <b>2-22-1967</b> , and that death occurred at <b>6:15 PM</b> from causes and on the date stated above.		22a. SIGNATURE <b>Peter P. Rodman, M.D.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Peter P. Rodman, M.D.</b>		22b. DATE SIGNED <b>APR 26 1967</b>	
22d. ADDRESS <b>8 Law Street, Aberdeen, Md.</b>		22e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>26 April 67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harford Memorial Gardens, Aberdeen, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Tarring Funeral Home</b>		25a. REC'D BY REGISTRAR <b>APR 26 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05224

CERTIFICATE OF DEATH

05222

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAURE DE GRACE</i>				c. LENGTH OF STAY IN 1b <i>DOA</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>				e. STREET ADDRESS <i>Stephney Rd. Rt #1 Box 88</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>FRANCES R. PEEVY</i>		4. DATE OF DEATH Month Day Year <i>April 25 1967</i>		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14 1889</i>	9. AGE (In years last birthday) <i>77</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Berryman Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Daniel Webster</i>				14. MOTHER'S MAIDEN NAME <i>Mamie Williams</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>215-28-9016</i>		17. INFORMANT Address <i>Rt #1 Box 88</i> <i>Mr. John C. Peery, Aberdeen, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Essential Hypertension</i> DUE TO (c) <i>Terminal</i> 15 yr.						INTERVAL BETWEEN ONSET AND DEATH <i>Terminal</i> <i>15 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
2da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4-25-1967</i> to <i>4-25-1967</i> , that (I) (we) last saw the deceased alive on <i>4-25-1967</i> , and that death occurred at <i>10:00</i> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Peter P. Rodman M.D.</i>				22b. DATE SIGNED <i>4-25-67</i>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <i>Aberdeen Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>April 29, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Aberdeen Harford Co. Md.</i>	
24. FUNERAL DIRECTOR <i>Otelia J. Bullock, Harre de Grace, Md.</i>				25. REG'D BY REGISTRAR DATE <i>APR 25 1967</i>			
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>1</div> <div> <div>4</div> <div>05225</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>05223</div> </div>									
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>			c. LENGTH OF STAY IN 1b <u>11 hrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE 121</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSP.</u>					d. STREET ADDRESS <u>661 OTSEGO ST</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>STANLEY</u> Middle <u>PONCEZ</u> Last <u>PONCEZ</u>					4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1967</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/23/1912</u>		9. AGE (in years last birthday) <u>55</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Works</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Broughton Pa.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Paul Poncez</u>					14. MOTHER'S MAIDEN NAME <u>Katherine Puksey</u> <u>3814 Dupont Ave</u> <u>Brooklyn N.Y. 10469</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>232-26-9132</u>		17. INFIRMANT <u>Mrs Della Newman</u> Address <u></u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u></u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April 9, 1967</u> to <u>April 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 10, 1967</u> , and that death occurred at <u>9:04</u> M. from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u></u>					22d. ADDRESS <u></u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>			23b. DATE THEREOF <u>4/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union</u>			23d. LOCATION (City, town or county) (State) <u>Chesapeake W. Va.</u>	
24. FUNERAL DIRECTOR <u>Benjamin L. Hare, Jr., Inc.</u>					25a. REC'D BY REGISTRAR <u>APR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Item #8 Film #G387 4/27/67

CERTIFICATE OF DEATH

05224

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> 15.3	
c. LENGTH OF STAY IN lb <u>3 days</u>		d. STREET ADDRESS <u>1143 Bushkill ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>WILLIAM</u> Middle <u>POTOMIS</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 6, 1896</u>
9. AGE (In years lost birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Belt STEEL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN POTOMIS</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET GETCHONIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WORLD WAR #1</u>		16. SOCIAL SECURITY NO. <u>174-10-8356</u>	
17. INFORMANT <u>Mrs. Sallie R. Potomis</u>		Address <u>1143 Bushkill ST Easton, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia &amp; Cardiac decompensation</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Carcinoma of lung</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) this hospital attended the deceased from <u>4-7</u> , 19 <u>67</u> , to <u>4-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-9</u> , 19 <u>67</u> , and that death occurred at <u>7:35 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>AW. GRIGOLEIT MD</u>		22b. DATE SIGNED <u>4/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>AW. GRIGOLEIT</u>		22d. ADDRESS <u>Haure de Grace</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>APRIL 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOLY SAVIOR CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>BETHLEHEM, North. PA.</u>
24. FUNERAL DIRECTOR <u>R. Madison Mitchell, Haure de Grace, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

02524

STATE OF OHIO

02524

By  
1/2

Commissioner of Land  
Revenue & Public Improvement

4/1/01

State of Ohio

Wm. E. Rice  
August 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove or on papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05227

## CERTIFICATE OF DEATH

05225

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harbide Grace</u>		c. LENGTH OF STAY in 1b <u>23 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial</u>		d. STREET ADDRESS <u>Fallston Rd 1 Box 87</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Cloud Pyle</u>		4. DATE OF DEATH <u>4</u> Month <u>4</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>FEB. 13, 1889</u> 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Green Creek Seal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	9. AGE (In years lost birthday) <u>78</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>PA. Penna</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Carleton J Pyle</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mercer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>190-16-9236</u>	
17. INFORMANT <u>DEAN RICHARDS PYLE</u>		Address <u>FALLSTON MD Box 87</u>	
18. CAUSE OF DEATH (Enter only one cause per line (or (d), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>A.S. C.V.D., Class IV, D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>—</u> (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Prostatic hypertrophy and urinary retention</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/12</u> , 19 <u>67</u> to <u>April 4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>April 4</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>4/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harbide Grace, Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>APRIL 8, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LOVORN PARK CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO MD.</u>	
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>		25a. REG'D BY REGISTRAR <u>APR 7 1967</u>	
ADDRESS <u>HAYRE DE GRACE MD</u>		25b. REGISTRAR'S SIGNATURE <u>James J. ...</u>	

00333

DEPARTMENT OF STATE

00333

*[Faint, mostly illegible handwritten text, possibly a memorandum or letter. Some words like "To:", "From:", and "Subject:" are faintly visible.]*

TO: <i>[illegible]</i>		FROM: <i>[illegible]</i>	
SUBJECT: <i>[illegible]</i>		DATE: <i>[illegible]</i>	
REFERENCE: <i>[illegible]</i>		ACTION: <i>[illegible]</i>	
REMARKS: <i>[illegible]</i>		APPROVAL: <i>[illegible]</i>	
SIGNATURE: <i>[illegible]</i>		TITLE: <i>[illegible]</i>	

*[Vertical text on the right margin, possibly a classification or filing code.]*

05228

CERTIFICATE OF DEATH

05226

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>Conowingo, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Ratliff</u>		4. DATE OF DEATH <u>4/3/67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Marvin Ratliff</u>		14. MOTHER'S MAIDEN NAME <u>Betty Streed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Marvin Ratliff - Conowingo, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7543 Congenital Heart Disease</u> DUE TO (b) <u>Interatrial Septic Defect</u> DUE TO (c) <u>Patent Ductus Arteriosus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/2, 1967</u> to <u>4/3, 1967</u> , that (I) (we) last saw the deceased alive on <u>4/3, 1967</u> , and that death occurred at <u>5:17</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Hahn</u>		22b. DATE SIGNED <u>4/3/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>4/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>	23d. LOCATION (City or town) (County) (State) <u>Rome Va.</u>
24. FUNERAL DIRECTOR <u>Conowingo Rm Harford Shore, Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>APR 10 1967</u>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05229					05227						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <u>Harford</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>						
c. LENGTH OF STAY IN 1b <u>2 yrs.</u>					d. STREET ADDRESS <u>Jarrettsville Road</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Convalescing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
<u>Roberta R. Reynolds</u>						<u>April 11 19 67</u>					
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH			9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
<u>Female</u>	<u>White</u>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>4/10/1868</u>			<u>99</u> yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Stafford, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Emmor Rees</u>					14. MOTHER'S MAIDEN NAME <u>Priscilla Ross</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>218-52-2203</u>		17. INFORMANT <u>Mrs. Priscilla Stansbury Balto. Md.</u>			Address <u>112 W. University Parkway</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Gen. Arteriosclerosis</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>30 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 20</u> , 19 <u>47</u> , to <u>Apr. 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Apr. 30</u> , 19 <u>67</u> , and that death occurred at <u>1 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert Barthel</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Apr. 11/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Robert Barthel M.D.</u>					22d. ADDRESS <u>Forest Hill, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
<u>Burial</u>			<u>4/13/1967</u>		<u>William Watters</u>			<u>Coontown, Maryland</u>			
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>					ADDRESS <u>Jarrettsville, Md.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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APR 13 1967

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## CERTIFICATE OF DEATH

05228

1. PLACE OF DEATH a. COUNTY <b>Hafford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route #3,</b>		d. STREET ADDRESS <b>Route #3, Box 69</b>	
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>W.</b> Last <b>RICHARDSON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 July 1893</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Harford County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George E. Wright</b>		14. MOTHER'S MAIDEN NAME <b>Emma Elizabeth James</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-46-1087</b>	
17. INFORMANT <b>G. Willard Richardson, Aberdeen, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4500</b> DUE TO <b>Cardiogenic heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic heart and</b> (c) <b>lung disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>over 2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>7:30 PM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>L. Mazzi</b>		22b. DATE SIGNED <b>4/5/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Mazzi, M.D.</b>		22d. ADDRESS <b>Havre de Grace, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7 April 67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Spesutia Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Perryman (Harford) Md.</b>	
24. FUNERAL DIRECTOR <b>Walter Macomber Jr.</b>		25a. REC'D BY REGISTRAR <b>APR 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02538

CONTRACT OF SALE

02538

02538

Blank document with faint horizontal lines and a large circular stamp in the center.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05231

CERTIFICATE OF DEATH

05229

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVERDEGRACE</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>					
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Benson</u>				121					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>703 Whitaker Mill Rd.</u>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F.</u> Last <u>SHANAHAN</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>29</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4 1905</u>			
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Care Taker C.F.A.C. Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD. Balto.</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>MD. Balto.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Shanahan</u>				14. MOTHER'S MAIDEN NAME <u>Louise Kearney</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>015-01-2332</u>					
17. INFORMANT <u>Kathryn L. Shanahan</u>				Address <u>703 Whitaker Mill Rd</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma head of Pancreas with</u> <u>157X</u> DUE TO (b) <u>bilary obstruction and massive</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c) <u>bilateral adrenal metastases</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>3</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> , 19 <u>67</u> , to <u>APRIL 29 1967</u> that (I) (we) last saw the deceased alive on <u>APRIL 29 1967</u> , and that death occurred at <u>10<sup>45</sup> A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Edward C. Loomis</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/29/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loomis</u>				22d. ADDRESS <u>HAVERDEGRACE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Long Green Md.</u>			
24. FUNERAL DIRECTOR <u>Dignel Bros Inc.</u>				ADDRESS <u>7110 Belair Rd</u>		25a. REC'D BY REGISTRAR <u>6</u> DATE <u>MAY 3 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

05332

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FOR STATE  
HEALTH DEPT.

05232

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05230

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN lb <b>Edgewood</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital - DOA</b>		d. STREET ADDRESS <b>3917 Love Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>LEONARD</b> Last <b>SHEETS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23, 1929</b>
9. AGE (In years last birthday) yrs. <b>37</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>auto</b>	
11. BIRTHPLACE (State or foreign country) <b>Bakersville, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaac Sheets</b>		14. MOTHER'S MAIDEN NAME <b>Rose Fyre</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>409-460428</b>	
17. INFORMANT <b>Mrs. Evelyn Sheets, 5 W. Midland Ave.,</b>		Address <b>Balto., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto Accident</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>4:50 p.m.</b> <b>4-26 19 67</b>		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Widoughby Beach Rd Edgewood Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gerald C Palmer</b> M.D.		22. DATE SIGNED <b>4-26-67</b>	
EXAMINER'S NAME (Type) <b>Gerald C Palmer - M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>Apr 26, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Henline Funeral Home</b>		23d. LOCATION (City or Town) (County) (State) <b>Bakersville Mitchell Co., N.C.</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md. 21009</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 7-1-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 1 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05233 CERTIFICATE OF DEATH 05231											
1. PLACE OF DEATH a. COUNTY <u>HARFORD.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>						c. LENGTH OF STAY IN 1b <u>23 days.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>					
d. STREET ADDRESS <u>Rd # 1</u>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Lyman</u> Middle <u>Jones</u> Last <u>Smith.</u>						4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1967.</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20, 1981</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward B. Smith</u>						14. MOTHER'S MAIDEN NAME <u>Hanna Gunthrie</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>215-36-0014</u>		17. INFORMANT <u>MINNIE C. Smith</u>		Address <u>R.D. #1 North East, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Senility</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senility</u>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> , 19 <u>67</u> to <u>4-22</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4/22/67</u> and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward C. Loo</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/22/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>						22d. ADDRESS <u>Harre de Grace, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>4/26/67</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Bay View Meth</u>			23d. LOCATION (City, town or county) (State) <u>Cecil Co. Md.</u>		
24. FUNERAL DIRECTOR <u>Grant Funeral Home</u>						ADDRESS <u>Box 22 North East, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Items 8 & 9 Film G388 5/11/67 kk

05234

# CERTIFICATE OF DEATH

05232

1. PLACE OF DEATH a. COUNTY <b>Hartford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Hartford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Haure de Grace</b>		c. LENGTH OF STAY (In days) <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hartford Memorial</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A.</b> Last <b>Stephoe</b>		4. DATE OF DEATH Month <b>4</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/10/1841</b> 85
9. AGE (In years last birthday) <b>82</b>		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>28</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		12. KIND OF BUSINESS OR INDUSTRY <b>House work</b>	
13. BIRTHPLACE (County, State, or foreign country) <b>Delaware</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>William Long</b>		16. MOTHER'S MAIDEN NAME <b>Rebecca Ellwood</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>None</b>		18. SOCIAL SECURITY NO. <b>None</b>	
19. INFORMANT <b>Wini Fred. S. Powd.</b>		20. Address <b>Wil. Delaware</b>	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> DUE TO <b>A.S. Ch. D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>5-6 Years</b>		22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>	
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
25. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. <b>19</b> p.m.	26. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	27. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	28. (City or town) (County) (State)
29. I certify that (I) (this hospital) attended the deceased from <b>April 7, 1967</b> to <b>April 8, 1967</b> that (I) (we) last saw the deceased alive on <b>April 8, 1967</b> , and that death occurred at <b>6A</b> M, from causes and on the date stated above			
30. SIGNATURE <b>Edward C. Loo, M.D.</b>		31. DATE SIGNED <b>4/8/67</b>	
32. PHYSICIAN'S NAME (Type) <b>Edward C. Loo, M.D.</b>		33. ADDRESS <b>Haure de Grace, Md.</b>	
34. BURIAL, CREMATION, REMOVAL (Specify) <b>4/11/67</b>	35. DATE THEREOF <b>4/11/67</b>	36. NAME OF CEMETERY OR CREMATORY <b>Silverbrook</b>	37. LOCATION (City or Town) (County) (State) <b>Wilmington, New Castle, Del.</b>
38. FUNERAL DIRECTOR <b>P. P. P. Funeral Home, Elkton Maryland</b>		39. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05235

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05233

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2271 North</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u> 10.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Susquehanna River</u>		d. STREET ADDRESS <u>109 Prospect Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Francis Thomas, Jr.</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1942</u>
9. AGE (In years lost birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, County, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert F. Thomas, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Edith Haines</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-40-0863</u>	
17. INFORMANT <u>Martha L. Thomas, Item 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to drowning</u> 850X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell out of Boat</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>3-31</u> 19 <u>67</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Susquehanna River</u>		20f. (City or town) (County) (State) <u>Baltimore, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P. Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/Hill, MD</u>	
EXAMINER'S NAME (Type) <u>Gerald P. Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>4-14-67</u>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>	23d. LOCATION (City or Town) (County) (State) <u>Mt. Airy, Md.</u>
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>		25a. REC'D BY REGISTRAR DA <u>APR 17 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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05236

CERTIFICATE OF DEATH

05234

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>				c. LENGTH OF STAY IN b <b>Unk.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Citizens Nursing Home</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>			
d. STREET ADDRESS <b>614 Shamrock Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles Sthaley Thorn</b>				4. DATE OF DEATH <b>April 17, 1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 23, 1886</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>17</b>		IF UNDER 24 HRS. Hours <b>17</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Bordentown, N.J.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>David C. Thorn</b>				14. MOTHER'S MAIDEN NAME <b>Ida Z. Elliott</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mr. Charles S. Thorn Jr. Bel Air, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> 1538 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Adenocarcinoma of Colon</b> (a), stating the underlying cause last. DUE TO (c) <b>—</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>6 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 14, 1967</b> to <b>April 17, 1967</b> that (I) (we) last saw the deceased alive on <b>April 17, 1967</b> and that death occurred <b>1:00 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edward C. Loo, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward C. Loo, M.D.</b>				22d. ADDRESS <b>211 N. Union Ave. Havre de Grace, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>April 20, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bordentown Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bordentown, New Jersey</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington + Son Havre de Grace, Md</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>			
25b. REGISTRAR'S SIGNATURE				DATE <b>APR 20 1967</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05334

STATE OF TEXAS

1900

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "STATE OF TEXAS" and "1900" are visible.]*

FOR STATE  
HEALTH DEPT. **M**

05237

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05235

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Hartford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Hartford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hartford</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>Route #1, Box 247</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edward Turnbaugh</b>		4. DATE OF DEATH <b>April 6 1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 Feb. 1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore County Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Turnbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Cockran</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-6644-A</b>	
17. INFORMANT <b>Clarence D. Turnbaugh,</b>		Address <b>Churchville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 9123			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Tractor rolled on him</b>	
20c. TIME OF INJURY Month, Day, Year <b>4-6-1967</b> Hour a.m. <b>11:35</b> p.m. <b>DOX</b>		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Service Sta.</b>		20f. (City or town) <b>Hartford</b> (County) <b>Hartford</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gerald C Palmer</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>Be Air, ml.</b>	
EXAMINER'S NAME (Type) <b>Gerald C Palmer, MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>4-6-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9 April 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jarrettville Cemetery, Jarrettville, Md.</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Walter Macomber Jr.</b>		REC'D BY REGISTRAR <b>Charles Judge</b>	
25a. REGISTRAR'S SIGNATURE		DATE <b>APR 10 1967</b>	

0253



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05238

CERTIFICATE OF DEATH

05236

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>317 Wakefield Place</u>	
3. NAME OF DECEASED (Type or print) <u>John Henry Unglaub</u>		4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1874</u>
9. AGE (In years, long birthday) <u>93 yrs.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R.R.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Miller Unglaub</u>		14. MOTHER'S MAIDEN NAME <u>Wilehmina Haug</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>717-07-6971</u>	
17. INFORMANT Address <u>Doris J. Stemler, dght. above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 180X DUE TO (b) <u>Transitional Ca of left kidney &amp; bilateral</u> DUE TO (c) <u>acute + chronic pyelonephritis &amp; hematuria</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-24, 1967</u> to <u>4-29, 1967</u> , that (I) (we) last saw the deceased alive on <u>4/29/67</u> 19 <u>67</u> , and that death occurred at <u>4:15 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>AW Grigoleit MD</u>		22b. DATE SIGNED <u>4/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>AW GRIGOLEIT</u>		22d. ADDRESS <u>HARRE DE GRACE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Schimunek Funeral Home</u> <u>3331 Brehms Lane #13</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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June 27, 1971

From: R.R.

TO: R.R.

Subject: [illegible]

171-07-017

171-07-017

Enclosure

Transmitted by [illegible] & [illegible]  
sent + change [illegible] & [illegible]

X

4/21/71

THANK YOU

4/21/71

W. J. [illegible]

AW GRIFFIN

171-07-017

171-07-017

171-07-017

171-07-017

MAY 2 1971

MAY 2 1971

05233

## CERTIFICATE OF DEATH

05237

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN TB <u>10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>		d. STREET ADDRESS <u>666 GREEN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>-</u> Middle <u>Vantor</u> Last		4. DATE OF DEATH <u>April</u> Month <u>9</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/10/1892</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant Owner</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicholas Vantor</u>		14. MOTHER'S MAIDEN NAME <u>Hathlem</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Nathlem Vantor</u> Address <u>666 Green St. Apt. 3</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Standstill</u> 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardiac Decompensation</u> DUE TO (c) <u>A.S. C.V.D.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, bilateral pleural effusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>? &gt; 2 to 3 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>3/3/67</u> to <u>4/9/67</u> , that (I) (we) last saw the deceased alive on <u>4/9/67</u> , and that death occurred at <u>6:18 A.M.</u> from causes and on the date stated above.	
22a. SIGNATURE <u>Edward C. Loo, M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/9/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/12/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Havre de Grace Md.</u>	
24. FUNERAL DIRECTOR <u>Funerary Soc. Havre de Grace, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 12 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

02333

02333

NAME		DATE	
ADDRESS		CITY	
STATE		ZIP	
TELEPHONE		FAX	
E-MAIL		WEB	
BIRTHDAY		BIRTHPLACE	
MARRIAGE		DIVORCE	
CHILDREN		PARENTS	
EDUCATION		OCCUPATION	
HOUSING		VEHICLE	
FINANCIAL		CREDIT	
HEALTH		DISABILITY	
MILITARY		CRIMINAL	
RECORDS		REFERENCES	
SIGNATURE		STAMP	
DATE		TIME	
LOCATION		OFFICE	
DEPARTMENT		DIVISION	
SECTION		UNIT	
POSITION		RANK	
GRADE		SALARY	
BENEFITS		PENSION	
RETIREMENT		DISCOUNT	
VACATION		SICKLEAVE	
HOLIDAYS		FLEXIBILITY	
WORKING		SCHEDULE	
PERFORMANCE		EVALUATION	
FEEDBACK		IMPROVEMENT	
TRAINING		DEVELOPMENT	
GROWTH		ACHIEVEMENT	
CONTRIBUTION		IMPACT	
LEADERSHIP		TEAMWORK	
COMMUNICATION		PROBLEM-SOLVING	
DECISION-MAKING		CREATIVITY	
INNOVATION		ADAPTABILITY	
RESILIENCE		PERSEVERANCE	
DILIGENCE		THOROUGHNESS	
ATTENTION		DETAILS	
ORGANIZATION		PRIORITY	
EFFICIENCY		EFFECTIVENESS	
PRODUCTIVITY		QUALITY	
TIMELINESS		ACCURACY	
COMPLETION		SATISFACTION	
CUSTOMER		SERVICE	
RELATIONSHIP		LOYALTY	
TRUST		CREDIBILITY	
REPUTATION		IMAGE	
BRAND		IDENTITY	
VALUES		PRINCIPLES	
ETHICS		INTEGRITY	
HONESTY		TRANSPARENCY	
ACCOUNTABILITY		RESPONSIBILITY	
COMMITMENT		DEDICATION	
PASSION		ENTHUSIASM	
ENERGY		POSITIVITY	
OPTIMISM		CONFIDENCE	
SELF-ESTEEM		RESPECT	
EMPATHY		SYMPATHY	
UNDERSTANDING		TOLERANCE	
PATIENCE		CALMNESS	
COMPOSURE		COMposure	
GRACE		ELEGANCE	
CHARM		CHARISMA	
WIT		HUMOR	
SARSENSE		CURIOSITY	
INTEREST		KNOWLEDGE	
WISDOM		EXPERIENCE	
SKILL		Talent	
ABILITY		CAPABILITY	
POTENTIAL		ACHIEVEMENT	
REALIZATION		FULFILLMENT	
SATISFACTION		CONTENTMENT	
PEACE		HARMONY	
BALANCE		WELL-BEING	
HEALTH		HAPPINESS	
JOY		LOVE	
GIVENESS		RECEIVING	
GRATITUDE		APPRECIATION	
ACKNOWLEDGMENT		RECOGNITION	
PRAISE		COMPLIMENT	
ENCOURAGEMENT		SUPPORT	
HELP		ASSISTANCE	
GUIDANCE		DIRECTION	
INFORMATION		KNOWLEDGE	
UNDERSTANDING		WISDOM	
SKILL		Talent	
ABILITY		CAPABILITY	
POTENTIAL		ACHIEVEMENT	
REALIZATION		FULFILLMENT	
SATISFACTION		CONTENTMENT	
PEACE		HARMONY	
BALANCE		WELL-BEING	
HEALTH		HAPPINESS	
JOY		LOVE	
GIVENESS		RECEIVING	
GRATITUDE		APPRECIATION	
ACKNOWLEDGMENT		RECOGNITION	
PRAISE		COMPLIMENT	
ENCOURAGEMENT		SUPPORT	
HELP		ASSISTANCE	
GUIDANCE		DIRECTION	
INFORMATION		KNOWLEDGE	
UNDERSTANDING		WISDOM	
SKILL		Talent	
ABILITY		CAPABILITY	
POTENTIAL		ACHIEVEMENT	
REALIZATION		FULFILLMENT	
SATISFACTION		CONTENTMENT	
PEACE		HARMONY	
BALANCE		WELL-BEING	
HEALTH		HAPPINESS	
JOY		LOVE	
GIVENESS		RECEIVING	
GRATITUDE		APPRECIATION	
ACKNOWLEDGMENT		RECOGNITION	
PRAISE		COMPLIMENT	
ENCOURAGEMENT		SUPPORT	
HELP		ASSISTANCE	
GUIDANCE		DIRECTION	
INFORMATION		KNOWLEDGE	
UNDERSTANDING		WISDOM	
SKILL		Talent	
ABILITY		CAPABILITY	
POTENTIAL		ACHIEVEMENT	
REALIZATION		FULFILLMENT	
SATISFACTION		CONTENTMENT	
PEACE		HARMONY	
BALANCE		WELL-BEING	
HEALTH		HAPPINESS	
JOY		LOVE	
GIVENESS		RECEIVING	
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ACKNOWLEDGMENT		RECOGNITION	
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ENCOURAGEMENT		SUPPORT	
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INFORMATION		KNOWLEDGE	
UNDERSTANDING		WISDOM	
SKILL		Talent	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u> c. LENGTH OF STAY IN 1b <u>2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>Rt 1; Box 107</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fred</u> First Middle Last 4. DATE OF DEATH <u>APRIL 22 1967</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>W</u> 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 29, 1889</u> 9. AGE (In years last birthday) <u>77</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Ret.)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Const. &amp; Bldg.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Alexx New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-07-8168</u> 17. INFORMANT <u>Frances E. Veeder, Aberdeen, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aortic aneurysm</u> 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 22, 1967</u> to <u>April 22, 1967</u> that (I) (we) last saw the deceased alive on <u>APRIL 22 1967</u> and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard J. Colfer</u> 22c. PHYSICIAN'S NAME (Type) <u>Richard J. Colfer, M.D.</u>		22b. DATE SIGNED <u>4/22/67</u> 22d. ADDRESS <u>Havre de Grace, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>25 April 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens, Bel Air, Maryland</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>John G. Tarring</u> Address <u>Tarring Funeral Home, Aberdeen, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 25 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

02538

02538

APR 2 1967

*Richard P. Gifford*

*April 27 1967*  
*X 4/27*

*Richard P. Gifford*  
*St. Louis*

210 - 8100

ST. LOUIS

ST. LOUIS, MO. 63101

ST. LOUIS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

05241

05239

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>		c. LENGTH OF STAY IN 1b <b>25 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>		d. STREET ADDRESS <b>2302 Mountain Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>--</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>MILTON</b> Last <b>WAGONER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 12, 1918</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>17</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transfer</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Harford County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mahlon C. Wagoner, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Zollie M. Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-07-9749</b>	
17. INFORMANT <b>Mahlon C. Wagoner, Jr.,</b>		Address <b>Joppa, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>For Advanced Pulmonary Tuberculosis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>9 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-1</b> , 19 <b>66</b> , to <b>4-17</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-17</b> , 19 <b>67</b> , and that death occurred at <b>4 p</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Fred O. Hodous</b>		22b. DATE SIGNED <b>4-18-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Fred O. Hodous, M.D.</b>		22d. ADDRESS <b>Edgewood, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 20, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bel Air R.D. Harford Md</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 20 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

025320

0256

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05242

05240

1. PLACE OF DEATH a. COUNTY <u>Harrison</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harrison</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisburg</u>		c. LENGTH OF STAY IN lb <u>12-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dr. H. H. H. Memorial Hospital</u>		d. STREET ADDRESS <u>Herald Rock's Road</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas E Walker</u>		4. DATE OF DEATH <u>April 21</u> 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28-1930</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>G.D. Shind</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert E. Walker</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Burton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Korean</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Chapman Funeral Home, Huntington W. Va.</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8254</u> <u>Exsanguination due to laceration</u> DUE TO (b) <u>Neck vessels</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>4-21-67</u> Hour a.m. <u>2:30</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <u>  </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dorrell C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Be/A i <u>  </u> DATE SIGNED <u>4-21-67</u>	
EXAMINER'S NAME (Type) <u>Geryd C Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>  </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>	23b. DATE THEREOF <u>4/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>  </u>	23d. LOCATION (City or Town) (County) (State) <u>Huntington W. Va.</u>
24. FUNERAL DIRECTOR <u>Conington &amp; Son, Hancock, Md.</u>		25. REC'D BY REGISTRAR <u>APR 25 1967</u>	
ADDRESS <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J.</u>	

Handwritten notes, mostly illegible due to blurriness. Some words like "The" and "is" are visible.

Handwritten notes at the bottom of the page, including what appears to be a signature or name "John" and some other illegible text.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05243

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05241

Items 1 & 23c & 23d Film (300 3/1/67) K

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARYLAND</b> c. LENGTH OF STAY IN 1b <b>New Jersey</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>673</b> <b>HARFORD COUNTY JAIL</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Bridgeton</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>673</b> <b>70 Vine Street</b>	
3. NAME OF DECEASED (Type or print) <b>EVERETT R. WALLS</b>		4. DATE OF DEATH Month Day Year <b>April 17, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years lost birthday) <b>41</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Caril-Padgett Funeral Home</b> <b>208 E. Commerce St. Bridgeton, N.J.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia by hanging</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (Partial)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hanged self in jail</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>4-17 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>jail (Partial)</b>		20f. (City or town) (County) (State) <b>HARFORD, MD.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		22. DATE SIGNED <b>April 17, 1967</b>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		23. DATE SIGNED <b>APR 24 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>4/18/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Center Grove Meth.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, N. J.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>APR 24 1967</b>	

14320

14320



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05244						05242					
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HARRE DE GRACE</u> c. LENGTH OF STAY IN 1b <u>Today</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEM. HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HARRE DE GRACE</u> d. STREET ADDRESS <u>612 BOURBON ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Boula H. Elizabeth</u>		Middle <u>WALTER</u>		Last <u>WALTER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1967</u>		5. AGE (in years last birthday) <u>71</u> yrs.		6. UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
7. SEX <u>F</u>		8. COLOR OR RACE <u>W</u>		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. DATE OF BIRTH <u>Aug. 27-1895</u>		11. PLACE OF BIRTH (County & State, or foreign country) <u>Harre de Grace, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		13. FATHER'S NAME <u>Walter M. Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT <u>Edmond Walter Harre de Grace, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO <u>Old rheumatic and arteriosclerotic</u> cause (a), stating the underlying cause last. (b) <u>Cardiovascular Disease</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>6 month</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Saddle Shaped thrombosis of abdominal + iliac arteries</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/8</u> , 19 <u>67</u> , to <u>4/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/28</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward C. Loo</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/28/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>						22d. ADDRESS <u>Harre de Grace, Ind.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>				23b. DATE THEREOF <u>5/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		23d. LOCATION (City, town or county) (State) <u>Harre de Grace Md</u>			
24. FUNERAL DIRECTOR <u>—</u>						ADDRESS <u>—</u>		25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05245 CERTIFICATE OF DEATH 05243

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ABERDEEN</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ABERDEEN</b>			
c. LENGTH OF STAY IN 1b <b>15 YRS</b>				d. STREET ADDRESS <b>126 CARROLL AVE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>126 CARROLL AVE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LOTTIE MAGROW WORTHINGTON</b>				4. DATE OF DEATH <b>APRIL 29 1967</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 13, 1883</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MO.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CHARLES C. BOWMAN</b>				14. MOTHER'S MAIDEN NAME <b>LUCY G. ORRELL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>218-10-3376-D</b>			
17. INFORMANT <b>Ms. Lucy Virginia McPhail, Aberdeen, MD</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>446X</b> DUE TO <b>Azotemia</b> Conditions, if any, which gave rise to immediate cause (b) <b>Anuria</b> (c) <b>Nephrosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 days</b> <b>3 mo</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>4-29-67</b> , that (I) (we) last saw the deceased alive on <b>4-28-67</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>P. Bowman</b>				22b. DATE SIGNED <b>5-1-67</b>			
22c. PHYSICIAN'S NAME <b>P. Bowman</b>				22d. ADDRESS <b>8 Law St. Aberdeen, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 2, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANGEL HILL CEM.</b>		23d. LOCATION (City, town or county) (State) <b>HAVRE DE GRACE, MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>			
25b. REGISTRAR'S SIGNATURE				25c. DATE <b>MAY 2 1967</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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*[Faint, mostly illegible text and markings throughout the page, including what appears to be a signature in the center and various handwritten notes.]*